# WSIB - Know Your Rights

# Goals

- Provide an overview of some of the important changes at the Workplace Safety and Insurance Board.
- To help you understand worker rights concerning workers' compensation.
- To help you to follow the proper procedures and receive the appropriate benefits.
- To provide you with an understanding the obligations required of the worker, union and employer
- It is not intended to be a legal document.

# AGENDA

- Recent WSIB history
- Steps to follow in the case of injury
- How to start a claim
- Worker - Union / Employer obligations
- Roles of the WSIB
- Return to Work
- Where do I go from here??

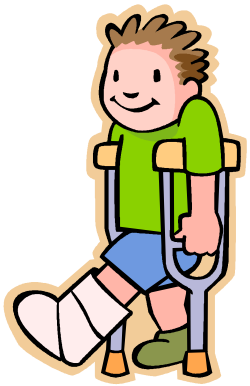
# Purpose of WSIA

- The purpose of this Act is to accomplish the following in a financially responsible and accountable manner:

- 1. To promote health and safety in workplaces.
- 2. To facilitate the return to work and recovery of workers who sustain personal injury arising out of and in the course of employment or who suffer from an occupational disease.
- 3. To facilitate the re-entry into the labour market of workers and spouses of deceased workers.
- 4. To provide compensation and other benefits to workers and to the survivors of deceased workers.

# Steps to follow in case of injury

- Immediately report all accidents/incidents to supervisor before leaving worksite
- Immediately seek medical attention
- Notify the union representative
- Note any witnesses
- Let people know of your pain
- Keep copies of all correspondence
- Keep a diary of all verbal communication



# How to Start a Claim

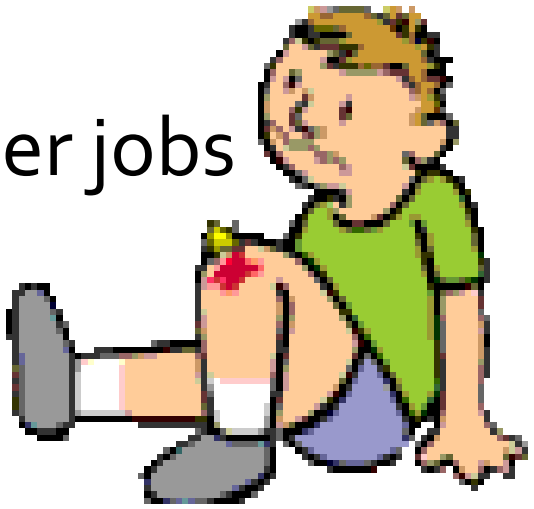
- Workers are required to apply for WSIB benefits:

- Three ways to apply for WSIB benefits:
  1. Form 6 – Worker form
  2. Form 7 – Employer form
  3. Form 8 – Health Professional 's Report Form

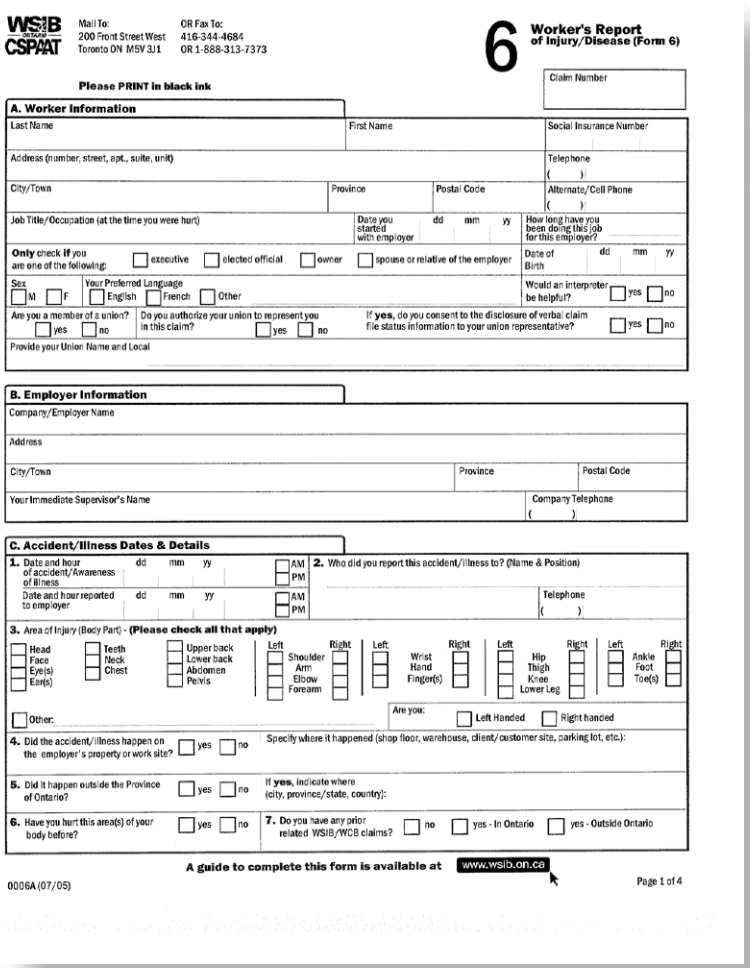
# Form 6 – Worker's Report of Injury / Form

- Normally arrives in the mail
- Worker should ensure accuracy and consistency in reporting:

1. Accident information
2. Areas of injury
3. Earnings – including other jobs
4. Witnesses



# Form 6 – Worker's Report of Injury



WSIB ONTARIO CSPAAT

Mail To: 200 Front Street West Toronto ON M5V 3J1
OR Fax To: 416-344-4684 OR 1-888-313-7373

**6 Worker's Report of Injury/Disease (Form 6)**

Please PRINT in black ink

Claim Number

**A. Worker Information**

Last Name | First Name | Social Insurance Number

Address (number, street, apt., suite, unit) | Telephone ( )

City/Town | Province | Postal Code | Alternate/Cell Phone ( )

Job Title/Occupation (at the time you were hurt) | Date you started with employer dd mm yy | How long have you been doing this job for this employer?

Only check if you are one of the following: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer | Date of Birth dd mm yy

Sex ☐ M ☐ F | Your Preferred Language ☐ English ☐ French ☐ Other | Would an interpreter be helpful? ☐ yes ☐ no

Are you a member of a union? ☐ yes ☐ no | Do you authorize your union to represent you in this claim? ☐ yes ☐ no | If yes, do you consent to the disclosure of verbal claim file status information to your union representative? ☐ yes ☐ no

Provide your Union Name and Local

**B. Employer Information**

Company/Employer Name

Address

City/Town | Province | Postal Code

Your Immediate Supervisor's Name | Company Telephone ( )

**C. Accident/Illness Dates & Details**

1. Date and hour of accident/Awareness of illness dd mm yy ☐ AM ☐ PM
   Date and hour reported to employer dd mm yy ☐ AM ☐ PM

2. Who did you report this accident/illness to? (Name & Position) | Telephone ( )

3. Area of Injury (Body Part) - **(Please check all that apply)**

| | | | Left | Right | Left | Right | Left | Right | Left | Right |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ Head<br>☐ Face<br>☐ Eye(s)<br>☐ Ear(s) | ☐ Teeth<br>☐ Neck<br>☐ Chest | ☐ Upper back<br>☐ Lower back<br>☐ Abdomen<br>☐ Pelvis | ☐ Shoulder<br>☐ Arm<br>☐ Elbow<br>☐ Forearm | | ☐ Wrist<br>☐ Hand<br>☐ Finger(s) | | ☐ Hip<br>☐ Thigh<br>☐ Knee<br>☐ Lower Leg | | ☐ Ankle<br>☐ Foot<br>☐ Toe(s) | |

☐ Other: | Are you: ☐ Left Handed ☐ Right handed

4. Did the accident/illness happen on the employer's property or work site? ☐ yes ☐ no | Specify where it happened (shop floor, warehouse, client/customer site, parking lot, etc.):

5. Did it happen outside the Province of Ontario? ☐ yes ☐ no | If yes, indicate where (city, province/state, country):

6. Have you hurt this area(s) of your body before? ☐ yes ☐ no

7. Do you have any prior related WSIB/WCB claims? ☐ no ☐ yes - In Ontario ☐ yes - Outside Ontario

A guide to complete this form is available at www.wsib.on.ca

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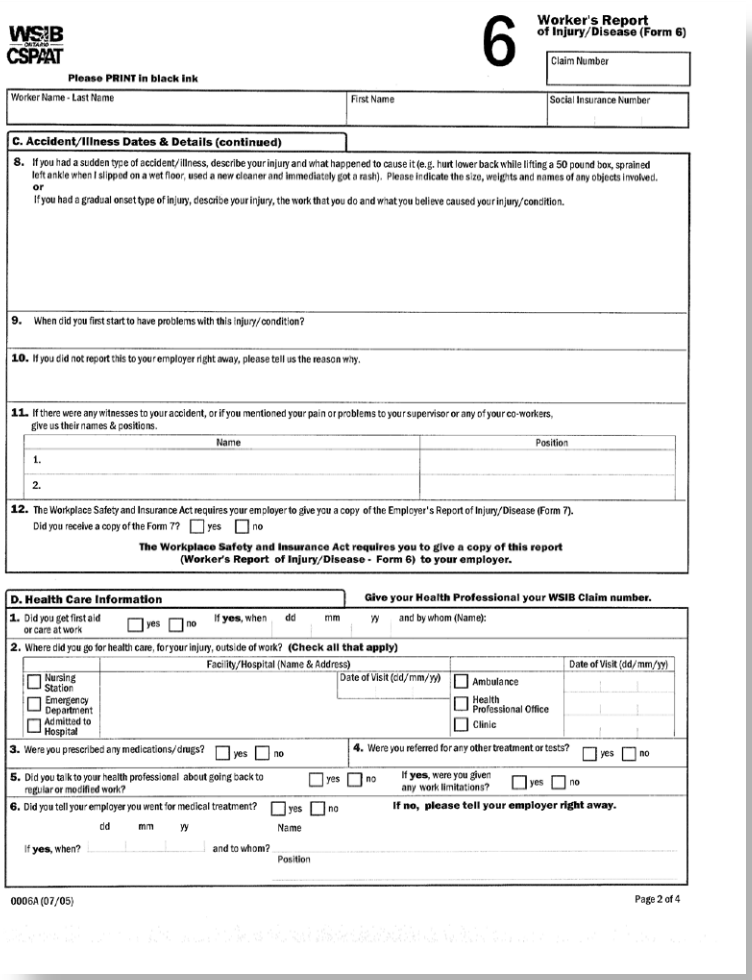
# Form 6 – Page 2



WSIB ONTARIO CSPAAT

**6** Worker's Report of Injury/Disease (Form 6)

Claim Number

Please PRINT in black ink

| Worker Name - Last Name | First Name | Social Insurance Number |
|---|---|---|
| | | |

**C. Accident/Illness Dates & Details (continued)**

**8.** If you had a sudden type of accident/illness, describe your injury and what happened to cause it (e.g. hurt lower back while lifting a 50 pound box, sprained left ankle when I slipped on a wet floor, used a new cleaner and immediately got a rash). Please indicate the size, weights and names of any objects involved.
**or**
If you had a gradual onset type of injury, describe your injury, the work that you do and what you believe caused your injury/condition.

**9.** When did you first start to have problems with this injury/condition?

**10.** If you did not report this to your employer right away, please tell us the reason why.

**11.** If there were any witnesses to your accident, or if you mentioned your pain or problems to your supervisor or any of your co-workers, give us their names & positions.

| | Name | Position |
|---|---|---|
| 1. | | |
| 2. | | |

**12.** The Workplace Safety and Insurance Act requires your employer to give you a copy of the Employer's Report of Injury/Disease (Form 7).
Did you receive a copy of the Form 7? ☐ yes ☐ no

**The Workplace Safety and Insurance Act requires you to give a copy of this report (Worker's Report of Injury/Disease - Form 6) to your employer.**

**D. Health Care Information** — **Give your Health Professional your WSIB Claim number.**

**1.** Did you get first aid or care at work ☐ yes ☐ no If **yes**, when dd mm yy and by whom (Name):

**2.** Where did you go for health care, for your injury, outside of work? **(Check all that apply)**

| | Facility/Hospital (Name & Address) | Date of Visit (dd/mm/yy) | | Date of Visit (dd/mm/yy) |
|---|---|---|---|---|
| ☐ Nursing Station | | | ☐ Ambulance | |
| ☐ Emergency Department | | | ☐ Health Professional Office | |
| ☐ Admitted to Hospital | | | ☐ Clinic | |

**3.** Were you prescribed any medications/drugs? ☐ yes ☐ no

**4.** Were you referred for any other treatment or tests? ☐ yes ☐ no

**5.** Did you talk to your health professional about going back to regular or modified work? ☐ yes ☐ no If **yes**, were you given any work limitations? ☐ yes ☐ no

**6.** Did you tell your employer you went for medical treatment? ☐ yes ☐ no **If no, please tell your employer right away.**

If **yes**, when? dd mm yy and to whom? Name Position

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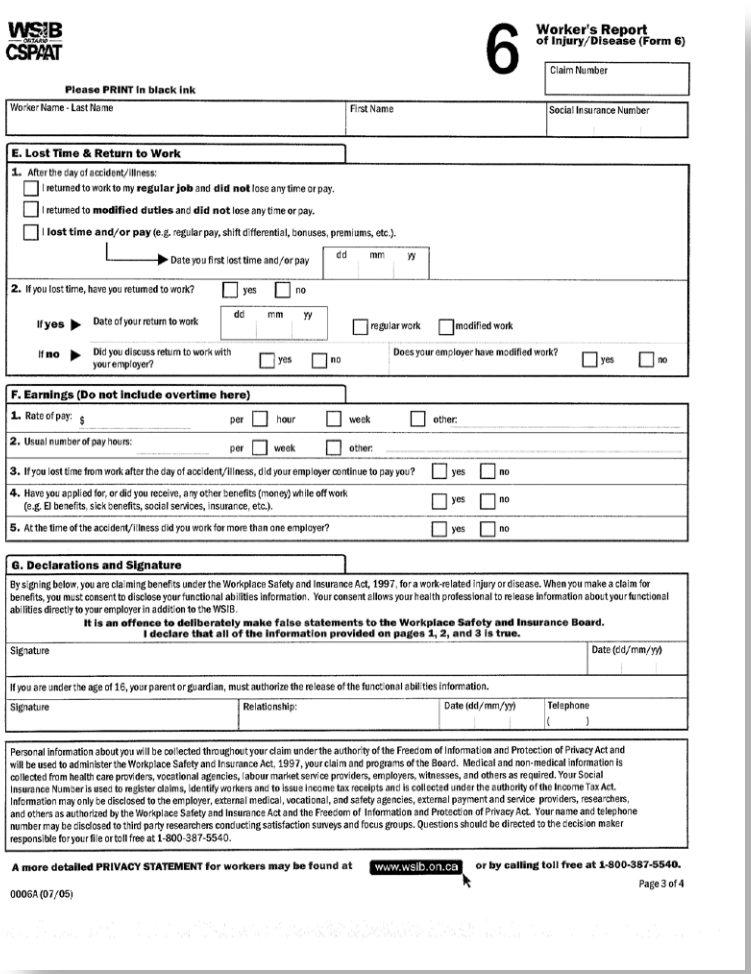
# Form 6 – Page 3



WSIB ONTARIO CSPAAT

**6 Worker's Report of Injury/Disease (Form 6)**

Claim Number

**Please PRINT in black ink**

| Worker Name - Last Name | First Name | Social Insurance Number |
|---|---|---|
| | | |

**E. Lost Time & Return to Work**

**1.** After the day of accident/illness:

- ☐ I returned to work to my **regular job** and **did not** lose any time or pay.
- ☐ I returned to **modified duties** and **did not** lose any time or pay.
- ☐ I **lost time and/or pay** (e.g. regular pay, shift differential, bonuses, premiums, etc.).

→ Date you first lost time and/or pay (dd mm yy)

**2.** If you lost time, have you returned to work? ☐ yes ☐ no

**If yes** ▶ Date of your return to work (dd mm yy) ☐ regular work ☐ modified work

**If no** ▶ Did you discuss return to work with your employer? ☐ yes ☐ no — Does your employer have modified work? ☐ yes ☐ no

**F. Earnings (Do not include overtime here)**

**1.** Rate of pay: $ _____ per ☐ hour ☐ week ☐ other: _____

**2.** Usual number of pay hours: _____ per ☐ week ☐ other: _____

**3.** If you lost time from work after the day of accident/illness, did your employer continue to pay you? ☐ yes ☐ no

**4.** Have you applied for, or did you receive, any other benefits (money) while off work (e.g. EI benefits, sick benefits, social services, insurance, etc.). ☐ yes ☐ no

**5.** At the time of the accident/illness did you work for more than one employer? ☐ yes ☐ no

**G. Declarations and Signature**

By signing below, you are claiming benefits under the Workplace Safety and Insurance Act, 1997, for a work-related injury or disease. When you make a claim for benefits, you must consent to disclose your functional abilities information. Your consent allows your health professional to release information about your functional abilities directly to your employer in addition to the WSIB.

**It is an offence to deliberately make false statements to the Workplace Safety and Insurance Board.**
**I declare that all of the information provided on pages 1, 2, and 3 is true.**

| Signature | Date (dd/mm/yy) |
|---|---|
| | |

If you are under the age of 16, your parent or guardian, must authorize the release of the functional abilities information.

| Signature | Relationship: | Date (dd/mm/yy) | Telephone ( ) |
|---|---|---|---|
| | | | |

Personal information about you will be collected throughout your claim under the authority of the Freedom of Information and Protection of Privacy Act and will be used to administer the Workplace Safety and Insurance Act, 1997, your claim and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, labour market service providers, employers, witnesses, and others as required. Your Social Insurance Number is used to register claims, identify workers and to issue income tax receipts and is collected under the authority of the Income Tax Act. Information may only be disclosed to the employer, external medical, vocational, and safety agencies, external payment and service providers, researchers, and others as authorized by the Workplace Safety and Insurance Act and the Freedom of Information and Protection of Privacy Act. Your name and telephone number may be disclosed to third party researchers conducting satisfaction surveys and focus groups. Questions should be directed to the decision maker responsible for your file or toll free at 1-800-387-5540.

**A more detailed PRIVACY STATEMENT for workers may be found at www.wsib.on.ca or by calling toll free at 1-800-387-5540.**

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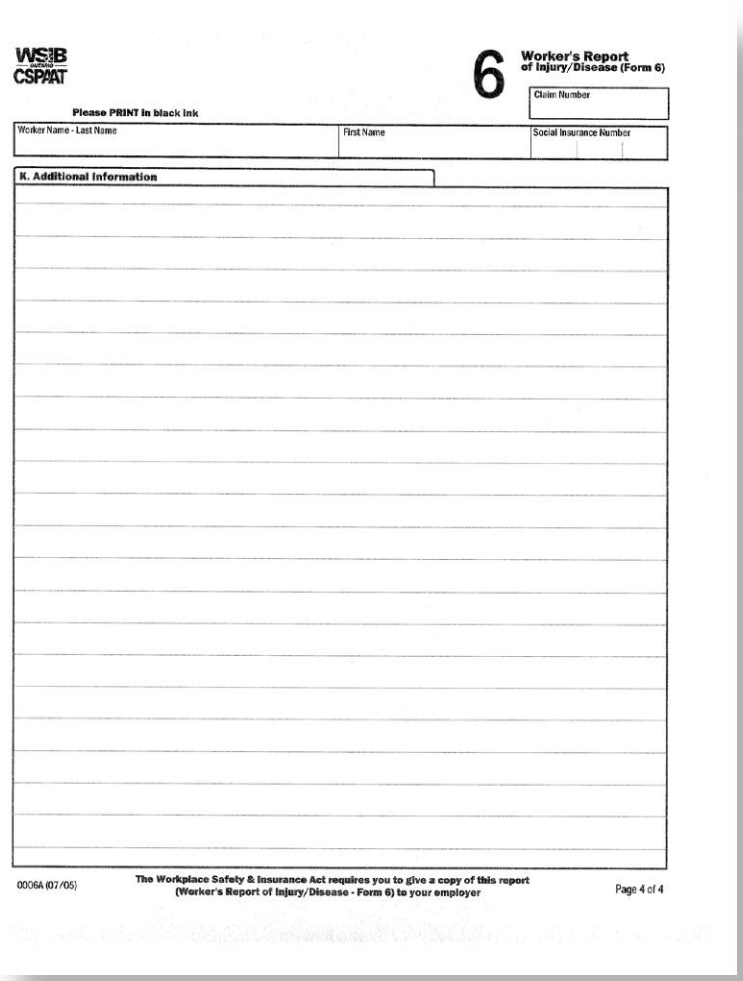
# Form 6 – Page 4



WSIB CSPAAT

**6** **Worker's Report of Injury/Disease (Form 6)**

Claim Number

**Please PRINT in black ink**

| Worker Name - Last Name | First Name | Social Insurance Number |
|---|---|---|
| | | |

**K. Additional Information**

0006A (07/05) **The Workplace Safety & Insurance Act requires you to give a copy of this report (Worker's Report of Injury/Disease - Form 6) to your employer** Page 4 of 4

# Form 7 – Employer's Report of Injury / Disease

The employer must complete a Form 7 when they are aware of a work related injury or occupational disease that causes a worker to:

1. Absent from regular work
2. Earns less than regular pay for regular work
3. Requires modified work at less than regular pay
4. Requires modified work for more than 7 calendar days
5. Requires health care

# Form 7 – Employer's Report of Injury / Disease

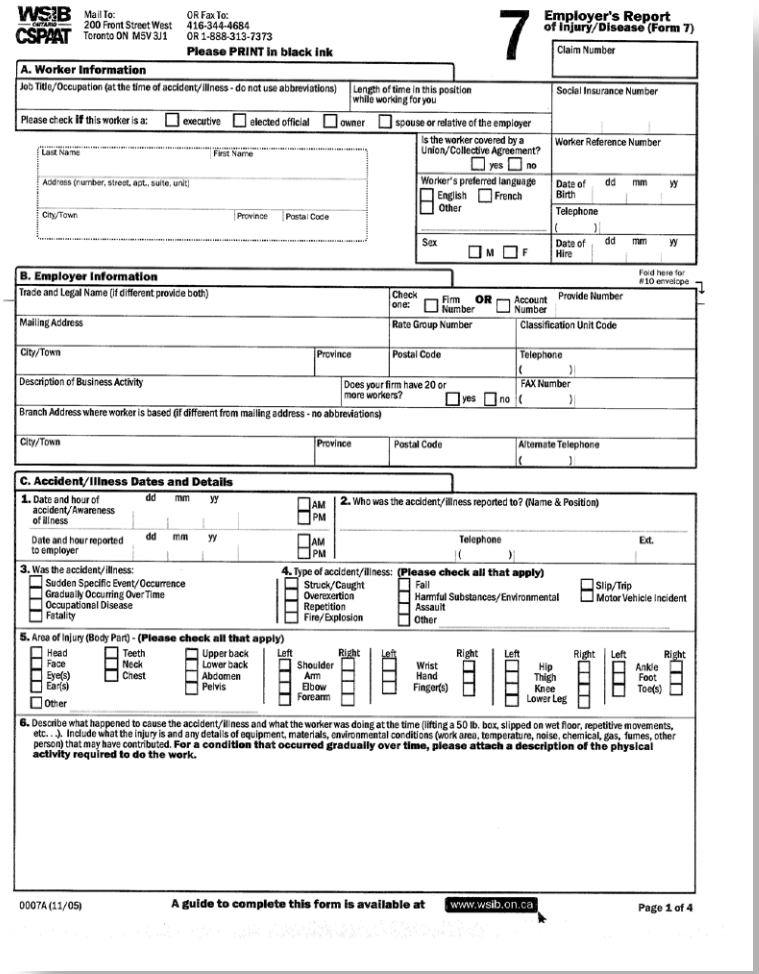
- Employer must submit the Form 7 to WSIB within 3 calendar days
- Employer, by law, must provide a completed copy of the Form 7 at the same time as they provide it to the WSIB

# Form 7 – Employer's Report of Injury / Disease

- Workers will receive a copy of the Form 7

- Check the form for accuracy
    1. Rate of pay
    2. Accident description
    3. Description of injury including specific parts of the body

# Form 7 – Employer's Report of Injury / Disease



WSIB ONTARIO CSPAAT

Mail To: 200 Front Street West Toronto ON M5V 3J1

OR Fax To: 416-344-4684 OR 1-888-313-7373

**Please PRINT in black ink**

**7 Employer's Report of Injury/Disease (Form 7)**

Claim Number

**A. Worker Information**

Job Title/Occupation (at the time of accident/illness - do not use abbreviations) | Length of time in this position while working for you | Social Insurance Number

Please check **if** this worker is a: ☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer

Last Name | First Name

Address (number, street, apt., suite, unit)

City/Town | Province | Postal Code

Is the worker covered by a Union/Collective Agreement? ☐ yes ☐ no

Worker Reference Number

Worker's preferred language ☐ English ☐ French ☐ Other

Date of Birth dd mm yy

Telephone ( )

Sex ☐ M ☐ F

Date of Hire dd mm yy

**B. Employer Information**

Fold here for #10 envelope

Trade and Legal Name (if different provide both)

Check one: ☐ Firm Number **OR** ☐ Account Number | Provide Number

Mailing Address | Rate Group Number | Classification Unit Code

City/Town | Province | Postal Code | Telephone ( )

Description of Business Activity | Does your firm have 20 or more workers? ☐ yes ☐ no | FAX Number ( )

Branch Address where worker is based (if different from mailing address - no abbreviations)

City/Town | Province | Postal Code | Alternate Telephone ( )

**C. Accident/Illness Dates and Details**

**1.** Date and hour of accident/Awareness of illness dd mm yy ☐ AM ☐ PM

Date and hour reported to employer dd mm yy ☐ AM ☐ PM

**2.** Who was the accident/illness reported to? (Name & Position)

Telephone ( ) Ext.

**3.** Was the accident/illness:
☐ Sudden Specific Event/Occurrence
☐ Gradually Occurring Over Time
☐ Occupational Disease
☐ Fatality

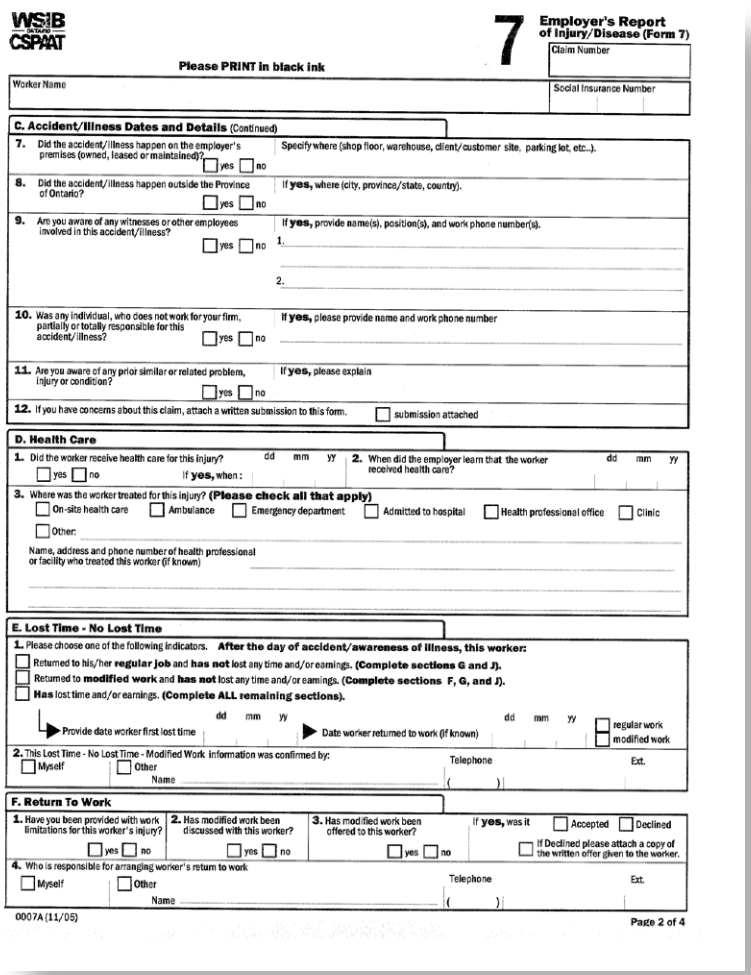
**4.** Type of accident/illness: **(Please check all that apply)**
☐ Struck/Caught
☐ Overexertion
☐ Repetition
☐ Fire/Explosion
☐ Fall
☐ Harmful Substances/Environmental
☐ Assault
☐ Other
☐ Slip/Trip
☐ Motor Vehicle Incident

**5.** Area of injury (Body Part) - **(Please check all that apply)**
☐ Head ☐ Face ☐ Eye(s) ☐ Ear(s) ☐ Other
☐ Teeth ☐ Neck ☐ Chest
☐ Upper back ☐ Lower back ☐ Abdomen ☐ Pelvis
Left ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm Right ☐
Left ☐ Wrist ☐ Hand ☐ Finger(s) Right ☐
Left ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg Right ☐
Left ☐ Ankle ☐ Foot ☐ Toe(s) Right ☐

**6.** Describe what happened to cause the accident/illness and what the worker was doing at the time (lifting a 50 lb. box, slipped on wet floor, repetitive movements, etc. . .). Include what the injury is and any details of equipment, materials, environmental conditions (work area, temperature, noise, chemical, gas, fumes, other person) that may have contributed. **For a condition that occurred gradually over time, please attach a description of the physical activity required to do the work.**

0007A (11/05) **A guide to complete this form is available at** www.wsib.on.ca **Page 1 of 4**

# Form 7 – Page 2



WSIB CSPAAT

**7** Employer's Report of Injury/Disease (Form 7)

Please PRINT in black ink

Claim Number

Worker Name | Social Insurance Number

**C. Accident/Illness Dates and Details** (Continued)

7. Did the accident/illness happen on the employer's premises (owned, leased or maintained)? ☐ yes ☐ no — Specify where (shop floor, warehouse, client/customer site, parking lot, etc..).

8. Did the accident/illness happen outside the Province of Ontario? ☐ yes ☐ no — If **yes,** where (city, province/state, country).

9. Are you aware of any witnesses or other employees involved in this accident/illness? ☐ yes ☐ no — If **yes,** provide name(s), position(s), and work phone number(s). 1. 2.

10. Was any individual, who does not work for your firm, partially or totally responsible for this accident/illness? ☐ yes ☐ no — If **yes,** please provide name and work phone number

11. Are you aware of any prior similar or related problem, injury or condition? ☐ yes ☐ no — If **yes,** please explain

12. If you have concerns about this claim, attach a written submission to this form. ☐ submission attached

**D. Health Care**

1. Did the worker receive health care for this injury? ☐ yes ☐ no — If **yes,** when : dd mm yy

2. When did the employer learn that the worker received health care? dd mm yy

3. Where was the worker treated for this injury? **(Please check all that apply)**
☐ On-site health care ☐ Ambulance ☐ Emergency department ☐ Admitted to hospital ☐ Health professional office ☐ Clinic
☐ Other:

Name, address and phone number of health professional or facility who treated this worker (if known)

**E. Lost Time - No Lost Time**

1. Please choose one of the following indicators. **After the day of accident/awareness of illness, this worker:**
☐ Returned to his/her **regular job** and **has not** lost any time and/or earnings. **(Complete sections G and J).**
☐ Returned to **modified work** and **has not** lost any time and/or earnings. **(Complete sections F, G, and J).**
☐ **Has** lost time and/or earnings. **(Complete ALL remaining sections).**

Provide date worker first lost time dd mm yy — Date worker returned to work (if known) dd mm yy — ☐ regular work ☐ modified work

2. This Lost Time - No Lost Time - Modified Work information was confirmed by: ☐ Myself ☐ Other — Name — Telephone ( ) — Ext.

**F. Return To Work**

1. Have you been provided with work limitations for this worker's injury? ☐ yes ☐ no

2. Has modified work been discussed with this worker? ☐ yes ☐ no

3. Has modified work been offered to this worker? ☐ yes ☐ no — If **yes,** was it ☐ Accepted ☐ Declined — ☐ If Declined please attach a copy of the written offer given to the worker.

4. Who is responsible for arranging worker's return to work ☐ Myself ☐ Other — Name — Telephone ( ) — Ext.

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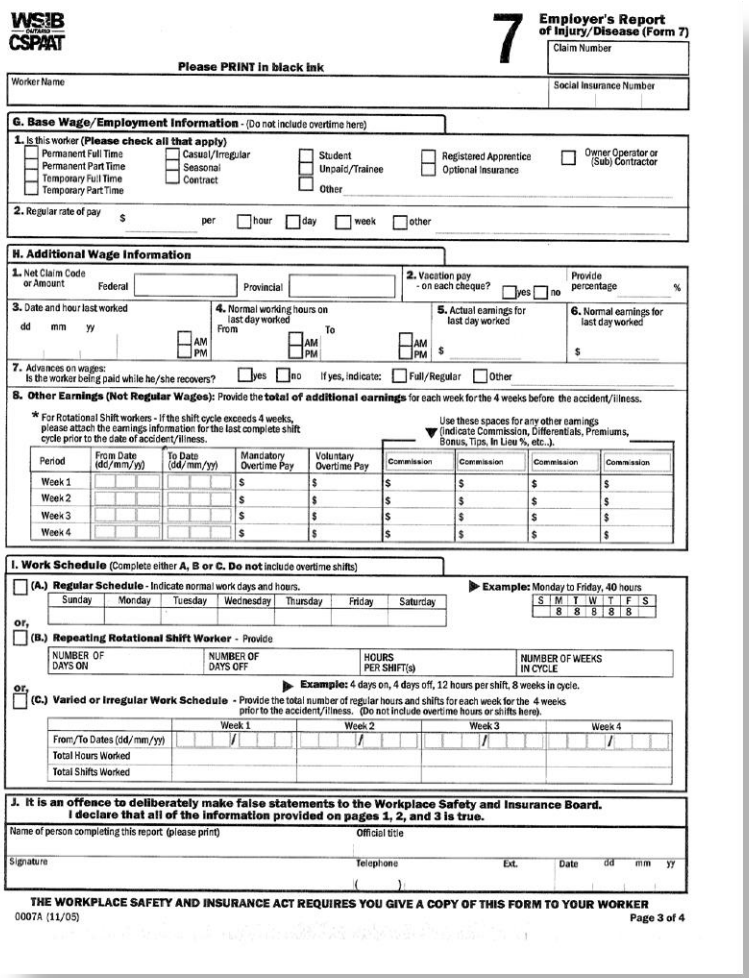
# Form 7 – Page 3



WSIB Ontario CSPAAT

**7** Employer's Report of Injury/Disease (Form 7)

Please PRINT in black ink

Claim Number

Worker Name

Social Insurance Number

**G. Base Wage/Employment Information** - (Do not include overtime here)

**1.** Is this worker **(Please check all that apply)**

☐ Permanent Full Time ☐ Permanent Part Time ☐ Temporary Full Time ☐ Temporary Part Time
☐ Casual/Irregular ☐ Seasonal ☐ Contract
☐ Student ☐ Unpaid/Trainee ☐ Other
☐ Registered Apprentice ☐ Optional Insurance
☐ Owner Operator or (Sub) Contractor

**2.** Regular rate of pay $ _____ per ☐ hour ☐ day ☐ week ☐ other _____

**H. Additional Wage Information**

**1.** Net Claim Code or Amount Federal _____ Provincial _____

**2.** Vacation pay - on each cheque? ☐ yes ☐ no Provide percentage _____ %

**3.** Date and hour last worked dd mm yy ☐ AM ☐ PM

**4.** Normal working hours on last day worked From ☐ AM ☐ PM To ☐ AM ☐ PM

**5.** Actual earnings for last day worked $ _____

**6.** Normal earnings for last day worked $ _____

**7.** Advances on wages: Is the worker being paid while he/she recovers? ☐ yes ☐ no If yes, indicate: ☐ Full/Regular ☐ Other

**8. Other Earnings (Not Regular Wages):** Provide the **total of additional earnings** for each week for the 4 weeks before the accident/illness.

* For Rotational Shift workers - If the shift cycle exceeds 4 weeks, please attach the earnings information for the last complete shift cycle prior to the date of accident/illness.

Use these spaces for any other earnings (Indicate Commission, Differentials, Premiums, Bonus, Tips, In Lieu %, etc..).

| Period | From Date (dd/mm/yy) | To Date (dd/mm/yy) | Mandatory Overtime Pay | Voluntary Overtime Pay | Commission | Commission | Commission | Commission |
|---|---|---|---|---|---|---|---|---|
| Week 1 | | | $ | $ | $ | $ | $ | $ |
| Week 2 | | | $ | $ | $ | $ | $ | $ |
| Week 3 | | | $ | $ | $ | $ | $ | $ |
| Week 4 | | | $ | $ | $ | $ | $ | $ |

**I. Work Schedule** (Complete either **A, B or C. Do not** include overtime shifts)

☐ **(A.) Regular Schedule** - Indicate normal work days and hours.

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|
| | | | | | | |

▶ **Example:** Monday to Friday, 40 hours

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| | 8 | 8 | 8 | 8 | 8 | |

or,

☐ **(B.) Repeating Rotational Shift Worker** - Provide

| NUMBER OF DAYS ON | NUMBER OF DAYS OFF | HOURS PER SHIFT(s) | NUMBER OF WEEKS IN CYCLE |
|---|---|---|---|
| | | | |

▶ **Example:** 4 days on, 4 days off, 12 hours per shift, 8 weeks in cycle.

or,

☐ **(C.) Varied or Irregular Work Schedule** - Provide the total number of regular hours and shifts for each week for the 4 weeks prior to the accident/illness. (Do not include overtime hours or shifts here).

| | Week 1 | Week 2 | Week 3 | Week 4 |
|---|---|---|---|---|
| From/To Dates (dd/mm/yy) | / | / | / | / |
| Total Hours Worked | | | | |
| Total Shifts Worked | | | | |

**J. It is an offence to deliberately make false statements to the Workplace Safety and Insurance Board. I declare that all of the information provided on pages 1, 2, and 3 is true.**

Name of person completing this report (please print) Official title

Signature Telephone ( ) Ext. Date dd mm yy

**THE WORKPLACE SAFETY AND INSURANCE ACT REQUIRES YOU GIVE A COPY OF THIS FORM TO YOUR WORKER**

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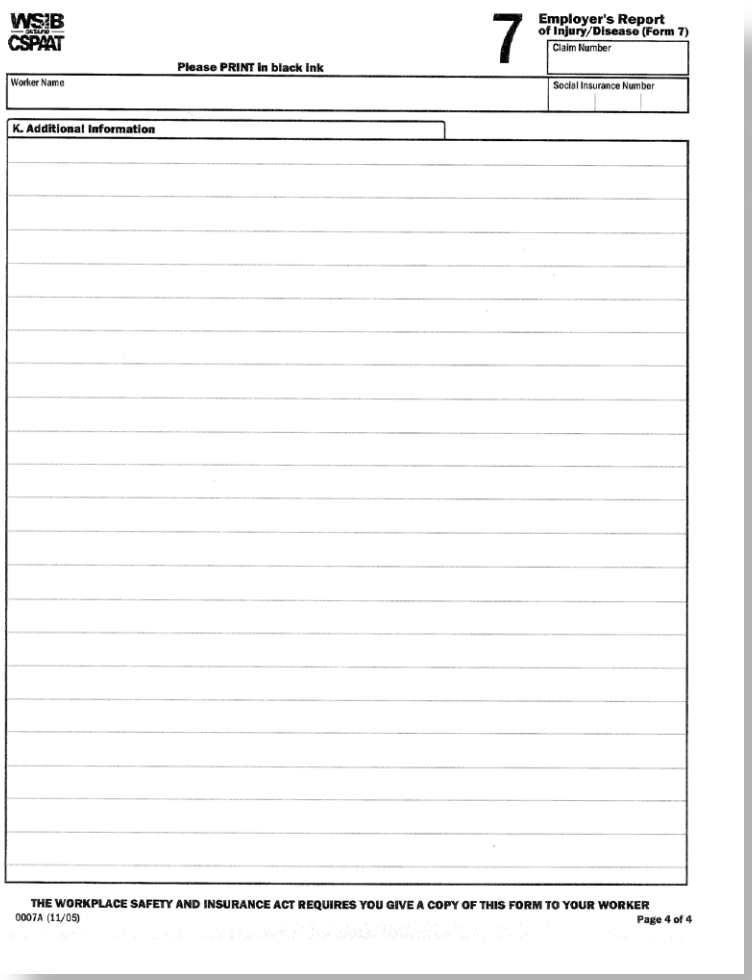
# Form 7 – Page 4



WSIB ontario CSPAAT

**7** Employer's Report of Injury/Disease (Form 7)

Please PRINT in black ink

Claim Number

Worker Name

Social Insurance Number

**K. Additional Information**

THE WORKPLACE SAFETY AND INSURANCE ACT REQUIRES YOU GIVE A COPY OF THIS FORM TO YOUR WORKER

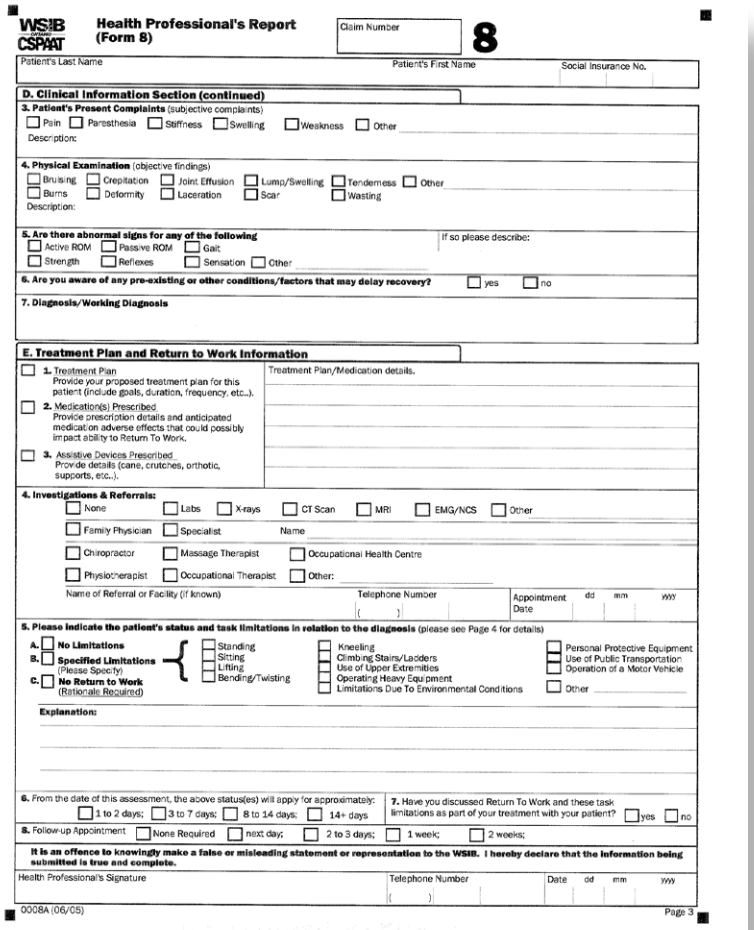
0007A (11/05)

Page 4 of 4

# Form 8 – Health Professional's Report

- Initial report of treating healthcare providers
- Worker should provide an accurate description of how accident happened
- Worker should ensure that all areas of injury are reported

# Form 8 – Health Professional's Report



WSIB CSPAAT **Health Professional's Report (Form 8)** Claim Number **8**

Patient's Last Name | Patient's First Name | Social Insurance No.

**D. Clinical Information Section (continued)**

**3. Patient's Present Complaints** (subjective complaints)
☐ Pain ☐ Paresthesia ☐ Stiffness ☐ Swelling ☐ Weakness ☐ Other
Description:

**4. Physical Examination** (objective findings)
☐ Bruising ☐ Crepitation ☐ Joint Effusion ☐ Lump/Swelling ☐ Tenderness ☐ Other
☐ Burns ☐ Deformity ☐ Laceration ☐ Scar ☐ Wasting
Description:

**5. Are there abnormal signs for any of the following** | If so please describe:
☐ Active ROM ☐ Passive ROM ☐ Gait
☐ Strength ☐ Reflexes ☐ Sensation ☐ Other

**6. Are you aware of any pre-existing or other conditions/factors that may delay recovery?** ☐ yes ☐ no

**7. Diagnosis/Working Diagnosis**

**E. Treatment Plan and Return to Work Information**

☐ **1.** Treatment Plan
Provide your proposed treatment plan for this patient (include goals, duration, frequency, etc..).

☐ **2.** Medication(s) Prescribed
Provide prescription details and anticipated medication adverse effects that could possibly impact ability to Return To Work.

☐ **3.** Assistive Devices Prescribed
Provide details (cane, crutches, orthotic, supports, etc..).

Treatment Plan/Medication details.

**4. Investigations & Referrals:**
☐ None ☐ Labs ☐ X-rays ☐ CT Scan ☐ MRI ☐ EMG/NCS ☐ Other
☐ Family Physician ☐ Specialist Name
☐ Chiropractor ☐ Massage Therapist ☐ Occupational Health Centre
☐ Physiotherapist ☐ Occupational Therapist ☐ Other:
Name of Referral or Facility (if known) | Telephone Number ( ) | Appointment Date dd mm yyyy

**5. Please indicate the patient's status and task limitations in relation to the diagnosis** (please see Page 4 for details)
A. ☐ **No Limitations**
B. ☐ **Specified Limitations** (Please Specify)
C. ☐ **No Return to Work** (Rationale Required)
☐ Standing ☐ Sitting ☐ Lifting ☐ Bending/Twisting
☐ Kneeling ☐ Climbing Stairs/Ladders ☐ Use of Upper Extremities ☐ Operating Heavy Equipment ☐ Limitations Due To Environmental Conditions
☐ Personal Protective Equipment ☐ Use of Public Transportation ☐ Operation of a Motor Vehicle ☐ Other

**Explanation:**

**6.** From the date of this assessment, the above status(es) will apply for approximately: ☐ 1 to 2 days; ☐ 3 to 7 days; ☐ 8 to 14 days; ☐ 14+ days

**7.** Have you discussed Return To Work and these task limitations as part of your treatment with your patient? ☐ yes ☐ no

**8.** Follow-up Appointment ☐ None Required ☐ next day; ☐ 2 to 3 days; ☐ 1 week; ☐ 2 weeks;

**It is an offence to knowingly make a false or misleading statement or representation to the WSIB. I hereby declare that the information being submitted is true and complete.**

Health Professional's Signature | Telephone Number ( ) | Date dd mm yyyy

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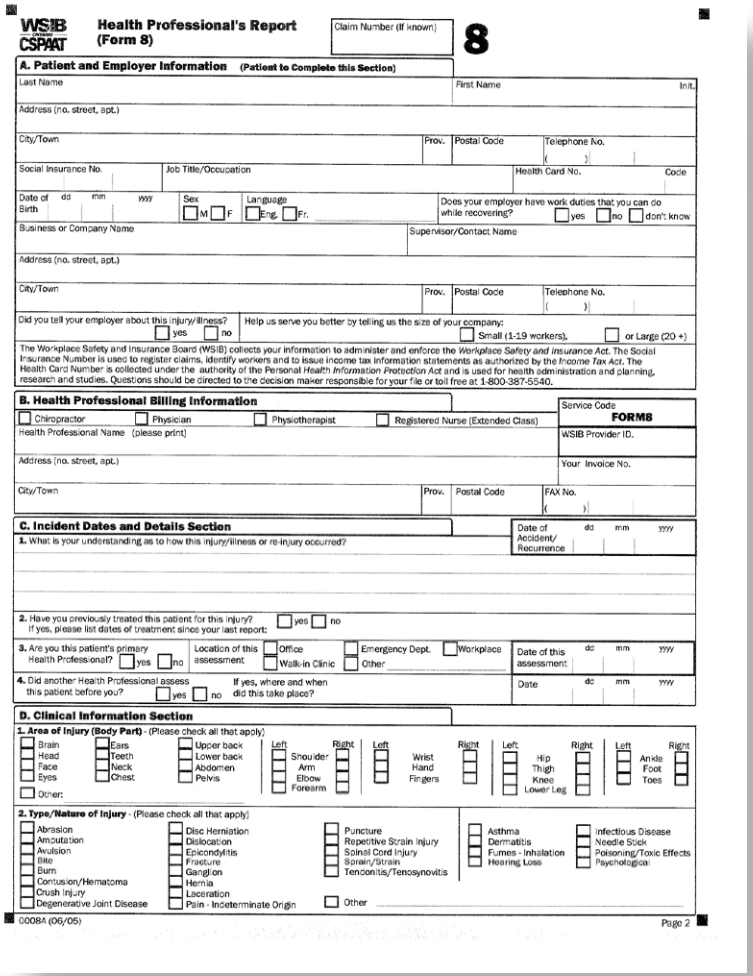
# Form 8 – Health Professional's Report



WSIB CSPAAT

**Health Professional's Report (Form 8)**

Claim Number (If known)

**8**

**A. Patient and Employer Information** (Patient to Complete this Section)

Last Name | First Name | Init.

Address (no. street, apt.)

City/Town | Prov. | Postal Code | Telephone No. ( )

Social Insurance No. | Job Title/Occupation | Health Card No. | Code

Date of Birth dd mm yyyy | Sex ☐ M ☐ F | Language ☐ Eng. ☐ Fr.

Does your employer have work duties that you can do while recovering? ☐ yes ☐ no ☐ don't know

Business or Company Name | Supervisor/Contact Name

Address (no. street, apt.)

City/Town | Prov. | Postal Code | Telephone No. ( )

Did you tell your employer about this injury/illness? ☐ yes ☐ no

Help us serve you better by telling us the size of your company: ☐ Small (1-19 workers), ☐ or Large (20 +)

The Workplace Safety and Insurance Board (WSIB) collects your information to administer and enforce the *Workplace Safety and Insurance Act*. The Social Insurance Number is used to register claims, identify workers and to issue income tax information statements as authorized by the *Income Tax Act*. The Health Card Number is collected under the authority of the Personal *Health Information Protection Act* and is used for health administration and planning, research and studies. Questions should be directed to the decision maker responsible for your file or toll free at 1-800-387-5540.

**B. Health Professional Billing Information**

Service Code **FORM8**

☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class)

Health Professional Name (please print) | WSIB Provider ID.

Address (no. street, apt.) | Your Invoice No.

City/Town | Prov. | Postal Code | FAX No. ( )

**C. Incident Dates and Details Section**

1. What is your understanding as to how this injury/illness or re-injury occurred? | Date of Accident/ Recurrence dd mm yyyy

2. Have you previously treated this patient for this injury? ☐ yes ☐ no
If yes, please list dates of treatment since your last report:

3. Are you this patient's primary Health Professional? ☐ yes ☐ no | Location of this assessment ☐ Office ☐ Emergency Dept. ☐ Workplace ☐ Walk-in Clinic ☐ Other | Date of this assessment dd mm yyyy

4. Did another Health Professional assess this patient before you? ☐ yes ☐ no | If yes, where and when did this take place? | Date dd mm yyyy

**D. Clinical Information Section**

1. **Area of Injury (Body Part)** - (Please check all that apply)

☐ Brain ☐ Head ☐ Face ☐ Eyes ☐ Ears ☐ Teeth ☐ Neck ☐ Chest ☐ Upper back ☐ Lower back ☐ Abdomen ☐ Pelvis

Left / Right: ☐ Shoulder ☐ Arm ☐ Elbow ☐ Forearm

Left / Right: ☐ Wrist ☐ Hand ☐ Fingers

Left / Right: ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg

Left / Right: ☐ Ankle ☐ Foot ☐ Toes

☐ Other:

2. **Type/Nature of Injury** - (Please check all that apply)

☐ Abrasion ☐ Amputation ☐ Avulsion ☐ Bite ☐ Burn ☐ Contusion/Hematoma ☐ Crush Injury ☐ Degenerative Joint Disease

☐ Disc Herniation ☐ Dislocation ☐ Epicondylitis ☐ Fracture ☐ Ganglion ☐ Hernia ☐ Laceration ☐ Pain - Indeterminate Origin

☐ Puncture ☐ Repetitive Strain Injury ☐ Spinal Cord Injury ☐ Sprain/Strain ☐ Tendonitis/Tenosynovitis

☐ Other

☐ Asthma ☐ Dermatitis ☐ Fumes - Inhalation ☐ Hearing Loss

☐ Infectious Disease ☐ Needle Stick ☐ Poisoning/Toxic Effects ☐ Psychological

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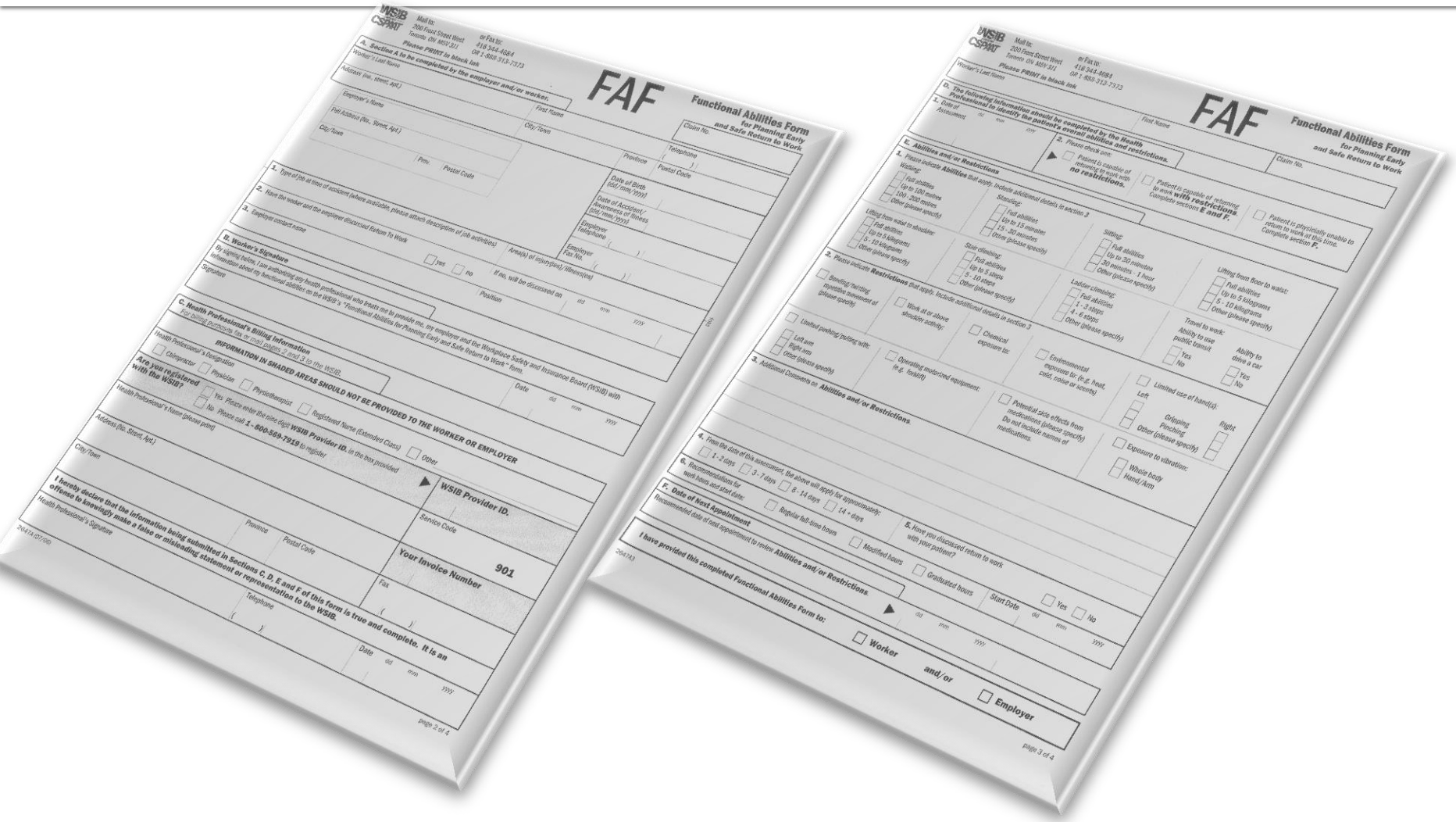
# What do I do ?

If in Doubt,
File a Claim

# FAF – Functional Abilities Form

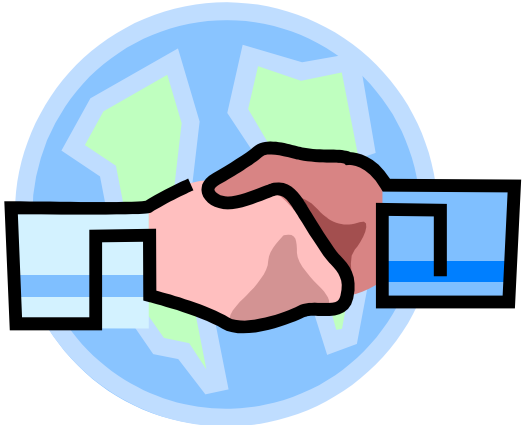
- Provides information for the purpose of assisting in Early and Safe Return to Work
- Notes worker restrictions / limitations
- There is no limit on the number of times a FAF is filled out

# FAF – Functional Abilities Form



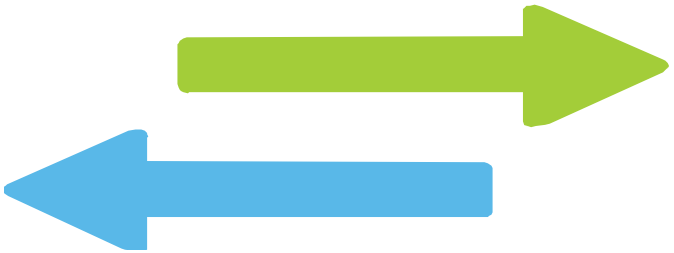
# Worker & Union Obligations

- Maintain communication with WSIB
- Maintain communication with Employer
- Notify WSIB of an Material Change in Circumstance
- Cooperate in Health Care
- Cooperate in Early & Safe Return to Work
- Assist in identifying suitable work



# Employer Obligations

- Maintain communication with WSIB
- Maintain communication with worker
- Notify WSIB of any Material Change in Circumstance
- Cooperate in ESRTW
- Identify Suitable Work



# Suitable Work Is:

- Suitable
- Safe
- Productive
- Available
- Within the workers' Functional Abilities
- If possible restores workers' pre-injury earnings

# Roles of the WSIB

- Eligibility Case Manager
- Case Manager
- Nurse Consultant
- Medical Consultant
- Work Reintegration Specialist

# Early & Safe Return to Work (ESRTW)

When a workplace injury or occupational disease occurs, the workplace parties (Worker, Union & Employer) are required under the Act to cooperate and work together in achieving the workers' early and safe return to appropriate work with the accident employer.

# Early & Safe Return to Work (ESRTW)

- Starts the moment the employer learns of injury
- "Early" means as soon as worker is "functionally fit"
- "Safe" means no risk of injury to worker or co-workers

# Early & Safe Return to Work (ESRTW)

- Workers are encouraged to attempt to perform the offered job
- WSIB RTW Specialists will provide mediation service
- Non-cooperation penalties

# Where to next ??

- CUPE National Representatives
- CUPE National WSIB Representatives
- CUPE Union Development (Education)

CUPE·SCFP | Canadian Union of Public Employees
Syndicat canadien de la fonction publique

# Questions


THANK
YOU